

COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

**IN THE MATTER OF
A HEARING UNDER *THE HEALTH PROFESSIONS ACT*,**

**AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DAWIT BIFTU**

**DECISION OF THE HEARING TRIBUNAL
OF THE
COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA**

**IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE
CONDUCT OF DAWIT BIFTU, LPN #43161, WHILE A MEMBER OF THE COLLEGE OF LICENSED
PRACTICAL NURSES OF ALBERTA (“CLPNA”)**

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via videoconference on October 17, 2024 with the following individuals present:

Hearing Tribunal:

Sarah Kawaleski, Licensed Practical Nurse (“LPN”) Chairperson
Amanda Rodzyniak, LPN
Kevin Kelly, Public Member
Don Wilson, Public Member

Staff:

Gregory Sim, Legal Counsel for the Complaints Director, CLPNA
Stephanie Karkutly, Complaints Officer, CLPNA
Sanah Sidhu, Director of Professional Conduct, CLPNA

Investigated Member:

Dawit Biftu, LPN (“Mr. Biftu” or “Investigated Member”)
Steven Robertson, Legal Counsel for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

There were no objections to the members of the Hearing Tribunal hearing the matter, and no Hearing Tribunal member identified a conflict. There were no objections to the jurisdiction of the Hearing Tribunal.

The Hearing was conducted by way of an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and a Joint Submission on Penalty.

(3) Background

Mr. Biftu was an LPN within the meaning of the *Health Professions Act* (the “Act”) at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Mr. Biftu was initially licensed as an LPN in Alberta on September 27, 2016.

The CLPNA received a complaint dated February 8, 2022 from Michelle Ujano, a member of the public, (the “Complaint”) pursuant to s. 55 of the Act. The Complaint advised of concerns with Mr. Biftu’s professional nursing practices.

By letter dated February 9, 2022, the Complaints Director of the CLPNA acknowledged receipt of the Complaint and appointed Judy Palyga, Investigator for the CLPNA (the “Investigator”), to conduct an investigation into the Complaint pursuant to s. 55(2)(d) of the Act.

On August 6, 2022, the Investigator submitted an Investigation Report to the Complaints Director.

By email dated January 17, 2023 the Complaints Director delegated their powers under Part 4 of the Act to Stephanie Karkutly, Complaints Officer (the “Complaints Officer”) pursuant to s. 20 of the Act.

The Complaints Officer reviewed the report and determined the investigation was concluded. The matter was referred to the Hearings Director for a hearing pursuant to s. 66(3)(a) of the Act. Mr. Biftu received notice of the referral, as well as, a copy of the Statement of Allegations and the Investigation Report, on January 25, 2023.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Mr. Biftu on April 26, 2023 for a hearing scheduled from August 8 - 11, 2023.

An adjournment was requested by the Solicitors for Mr. Biftu; and accordingly, the hearing was adjourned.

Subsequently, an Amended Statement of Allegations was provided to Mr. Biftu, along with an updated Notice of Hearing, Notice to Attend and Notice to Produce for this hearing, which was scheduled on October 17, 2024.

(4) Allegations

The Allegation in the Amended Statement of Allegations (the “Allegation”) is:

“It is alleged that DAWIT BIFTU, LPN, while practicing as a Licensed Practical Nurse engaged in unprofessional conduct by:

- 1) On or about January 13, 2022, failing to administer or accurately document on the Medication Administration Record the non-administration of medication to a resident as ordered:
 - a. failing to administer and accurately document on the Medication Administration Record the non-administration of Synthroid 75 mcg for resident TK at 0800 hours; and
 - b. failing to administer and accurately document on the Medication Administration Record the non-administration of Eltroxin 150 mcg or Sulfasalazine EC 500 mg for resident DP at 0800 hours; and

- c. failing to accurately document on the Medication Administration Record the non-administration of Zorvirax ointment 5% or Erythromycin ointment 5mg/gm for resident DR at 1200 hours; and
- d. failing to accurately document the non-administration of Lenoltec #3 for resident VC at 0800 and 1200 hours on one of the two Medication Administration Records.

It is further alleged that Dawit Biftu's conduct constitutes "unprofessional conduct" as defined in section 1(1)(pp)(i), (ii), and (xii) of the *Health Professions Act*, RSA 2000, c. H-7."

(5) Admission of Unprofessional Conduct

Section 70 of the Act permits an investigated member to make an admission of unprofessional conduct. An admission under s. 70 of the Act must be acceptable in whole or in part to the Hearing Tribunal.

Mr. Biftu acknowledged unprofessional conduct to all the allegations as evidenced by his signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and verbally admitted unprofessional conduct to all the allegations set out in the Statement of Allegations during the hearing.

Legal Counsel for the Complaints Director submitted that where there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances.

(6) Exhibits

The following exhibits were entered at the hearing:

- Exhibit #1: Amended Statement of Allegations
- Exhibit #2: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
- Exhibit #3: Joint Submission on Penalty

(7) Evidence

The evidence was adduced by way of Agreed Statement of Facts, and no witnesses were called to give *viva voce* testimony. The Hearing Tribunal accepts the evidence set out in the Agreed Statement of Facts which was admitted as Exhibit #2.

(8) Decision of the Hearing Tribunal and Reasons

The Hearing Tribunal is aware it is faced with a two-part task in considering whether a regulated member is guilty of unprofessional conduct. First, the Hearing Tribunal must make factual findings as to whether the alleged conduct occurred. If the alleged conduct occurred, it must then

proceed to determine whether that conduct rises to the threshold of unprofessional conduct in the circumstances.

The Hearing Tribunal has reviewed the documents included in Exhibit #2 and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Mr. Biftu's admission of unprofessional conduct as set out in the Agreed Statement of Facts as described above. Based on the evidence and submissions before it, the Hearing Tribunal did not identify exceptional circumstances that would justify not accepting the admission of unprofessional conduct from Mr. Biftu.

Allegation 1

Mr. Biftu admitted that on or about January 13, 2022, he engaged in unprofessional conduct by failing to administer or accurately document on the Medication Administration Record the non-administration of medication to a resident as ordered, with a number of particulars (each bolded, below).

In relation to Allegation 1, Mr. Biftu admitted the following:

Mr. Biftu worked at Auburn Heights Retirement Residence in Calgary, Alberta (the "Facility") at the time of the Allegation and held the position of Director of Care.

The Facility was in a COVID outbreak from January 2, 2022 to February 5, 2022. There were many staff members down with positive COVID tests and COVID-like symptoms. Mr. Biftu was covering for ill staff in addition to his work as Director of Care.

On January 13, 2022, Mr. Biftu worked at the Facility from 0700 hours to 1500 hours as an LPN, covering a day LPN shift.

Employees of the Facility were expected to use the QOLA, an electronic patient charting system, to document patient care.

Mr. Ronald Quitco, LPN ("Mr. Quitco") was a subordinate of Mr. Biftu at the Facility and was interviewed as a witness as part of the investigation.

a. failing to administer and accurately document on the Medication Administration Record the non-administration of Synthroid 75 mcg for resident TK at 0800 hours.

On January 13, 2022, Mr. Biftu provided care to resident TK who resided at the Facility.

Resident TK was ordered to receive a regular scheduled medication of one (1) tablet of Synthroid 75 mcg daily in the morning.

Resident TK's Medication Administration Record ("MAR") shows that one (1) tablet of Synthroid 75 mcg was administered at 0800 hours on January 13, 2022 by Mr. Biftu, as evidenced by his initials 'DB' in the corresponding box.

At approximately 2100 hours on January 13, 2022, Mr. Quitco found one (1) tablet of Synthroid 75 mcg inside the bubble pack of Resident TK's blister pack in the secured medication box in TK's room. Mr. Quitco completed a Medication Incident Report.

Mr. Biftu acknowledges that he failed administer Synthroid 75 mcg to resident TK as ordered on January 13, 2022.

Mr. Biftu acknowledges he signed Resident TK's MAR in error on January 13, 2022.

b. failing to administer and accurately document on the Medication Administration Record the non-administration of Eltroxin 150 mcg or Sulfasalazine EC 500 mg for resident DP at 0800 hours.

On January 13, 2022, Mr. Biftu provided care to resident DP who resided at the Facility.

Resident DP was ordered to receive a regular scheduled medication of (1) tablet of Eltroxin 150 mcg daily at 0800 hours, as well as two (2) tablets of Sulfasalazine EC 500 mg twice a day at 0800 hours and 2100 hours.

Resident DP's MAR shows that one (1) tablet of Eltroxin 150 mcg and two (2) tablets of Sulfasalazine EC 500 mg were administered to DP at 0800 hours on January 13, 2022 by Mr. Biftu, as evidenced by his initials 'DB' in the corresponding boxes.

At approximately 2100 hours on January 13, 2022, Mr. Quitco found one (1) tablet of Eltroxin 150 mcg and two (2) tablets of Sulfasalazine 500 mg inside the secured medication box in DP's room. Mr. Quitco completed a Medication Incident Report.

Mr. Biftu acknowledges that he failed administer one (1) tablet of Eltroxin 150 mcg and two (2) tablets of Sulfasalazine EC 500 mg to resident DP as ordered on January 13, 2022.

Mr. Biftu acknowledges he signed Resident DP's MAR in error on January 13, 2022.

c. failing to accurately document on the Medication Administration Record the non-administration of Zovirax ointment 5% or Erythromycin ointment 5mg/gm for resident DR at 1200 hours.

On January 13, 2022, Mr. Biftu provided care to resident DR who resided at the Facility.

Resident DR was ordered to receive a regular scheduled medication of three (3) daily applications of Zovirax ointment 5% and four (4) daily applications of Erythromycin ointment 5mg/gm.

Resident DR's MAR shows that the 1200 hours application of Zovirax ointment 5% was not administered to DR on January 13, 2022 as "1" was marked in the corresponding box by Mr. Biftu,

which indicates patient refusal. Secondly, the 1200 hours application of Erythromycin ointment 5mg/gm was administered to DR on January 13, 2022 by Mr. Biftu, as evidenced by his initials 'DB' in the corresponding box.

In contradiction, Resident DR's MAR shows that the administration of Rosuvastatin 10 mg at 1200 hours was marked with a "6" in the corresponding box by Mr. Biftu, which indicates the patient was absent from home.

It was determined that Resident DR was absent from the Facility at 1200 hours on January 13, 2022, and accordingly, there was inaccurate documentation in the MAR.

Mr. Biftu acknowledges he signed Resident DR's MAR in error on January 13, 2022.

d. failing to accurately document the non-administration of Lenoltec #3 for resident VC at 0800 and 1200 hours on one of the two Medication Administration Records.

On January 13, 2022, Mr. Biftu provided care to resident VC who resided at the Facility.

Resident VC was ordered to receive a regular scheduled medication of one (1) tablet of Lenoltec #3 four times daily.

Two MARs were produced during the investigation for resident VC. On MAR 1, the initials 'DB' can be seen for the 0800 hours dose of Lenoltec #3 on January 13, 2022. On MAR 2, Mr. Biftu marked "1" with a circle around it in the corresponding box, which indicates patient refusal regarding the medication administration of Lenoltec #3 at both 0800 hours and 1200 hours.

Mr. Biftu documented by hand in VC's Multidisciplinary Notes that, on January 13, 2022 at both 0809 hours and 1157 hours, he attended to resident VC to administer the prescribed doses of Lenoltec #3; however, the resident refused the medication at both times; accordingly, the medication was not administered.

VC's Narcotic Drug Count Sheet demonstrates zero quantity used and no change in quantity counted by the end of the date on January 13, 2023.

Mr. Quitco documented in QOLA on January 13, 2022 at 2338 hours that Mr. Biftu "acknowledged that he missed giving the medications (Lenoltec #3) and told writer (Mr. Quitco) to make an incident report.

Mr. Biftu acknowledges he signed MAR 1 in error and altered MAR 2 to match what he recorded in the multidisciplinary notes.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Biftu's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 1 did in fact occur.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

- i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
- ii. Contravention of the Act, a code of ethics or standards of practice;
- iii. Conduct that harms the integrity of the regulated profession.

Mr. Biftu demonstrated a lack of knowledge, skill, and judgment. Medication administration and documentation are core competencies of any LPN. On January 13, 2022, Mr. Biftu made multiple medication documentation errors when he failed to document the non-administration of several of his residents' medications. This demonstrated a lack of knowledge, skill and judgment as there could have been other errors made with patient medication that day due to his errors, putting patient health potentially at risk. Mr. Biftu should have had the knowledge to document correctly, and the judgment to ensure it was done correctly.

In addition, Mr. Biftu did not abide by the Code of Ethics for Licensed Practical Nurses in Canada adopted June 3, 2012 ("CLPNA Code of Ethics") and the Standards of Practice for Licensed Practical Nurses in Canada (2013) ("CLPNA Standards of Practice"). Information as to the particular code provisions and standards that were breached is set out below.

Finally, this conduct also harmed the integrity of the regulated profession. The public has an expectation that LPNs understand and maintain professional standards in medication administration and documentation. By Mr. Biftu's own admission, he failed to uphold these standards and made multiple errors in both documentation and medication administration.

The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out below and that such breaches are sufficiently serious to constitute unprofessional conduct. The specific provisions are set out below.

CLPNA Code of Ethics:

Principle 1: Responsibility to the Public - LPNs, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to members of the public. Principle 1 specifically provides that LPNs:

- 1.1 Maintain standards of practice, professional competence and conduct.

Principle 2: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:

- 2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities.
- 2.8 Use evidence and judgment to guide nursing decisions.

- 2.9 Identify and minimize risks to clients.

Principle 3: Responsibility to the Profession – LPNs have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically provides that LPNs:

- 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.
- 3.3 Practise in a manner that is consistent with the privilege and responsibility of self-regulation.
- 3.4 Promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws and regulations under which they are accountable.

Relating to the CLPNA Code of Ethics, Mr. Biftu's actions failed to demonstrate all of the above responsibilities. Mr. Biftu made multiple medication documentation errors as detailed above. When medications are not administered as required, patients can face negative impacts to their mental and physical health. Inaccurate patient records may later be relied on for the purposes of making health care decisions which are then grounded in incorrect information.

The public expects that LPNs maintain the standards of practice, professional competence and conduct at all times. Mr. Biftu failed to demonstrate these expectations that the public has and thereby could cause the public to lose confidence in the profession. He did not practice in a manner that is consistent with the privilege and responsibility of self-regulation.

The above proven allegations clearly demonstrate Mr. Biftu failed in his responsibilities to the public, the clients involved in each of the allegations, the public, the profession as well as himself.

CLPNA Standards of Practice:

Standard 1: Professional Accountability and Responsibility – LPNs are accountable for their practice and responsible for ensuring that their practice and conduct meet both the standards of the profession and legislative requirements. Standard 1 specifically provides that LPNs:

- 1.1 Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies.
- 1.6. Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised.
- 1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for Licensed Practical Nurses.

- 1.10 Maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

Standard 2: Knowledge-Based Practice – Licensed Practical Nurses possess knowledge obtained through practical nurse preparation and continuous learning relevant to their professional LPN practice.

- 2.7. Demonstrate understanding of their role and its interrelation with clients and other health care colleagues.
- 2.10. Recognize how LPN practice environments and other environmental factors affect professional practice and client outcomes and develop/modify care plans to assure client safety and well-being.

Standard 3: Service to the Public and Self-Regulation – LPNs practice nursing in collaboration with clients and other members of the health care team to provide and improve health care services in the best interests of the public. Standard 3 specifically provides that LPNs:

- 3.3 Support and contribute to an environment that promotes and supports safe, effective and ethical practice.
- 3.5 Provide relevant and timely information to clients and co-workers.
- 3.6 Demonstrate an understanding of self-regulation by following the standards of practice, the code of ethics and other regulatory requirements.

The proven Allegation in this matter clearly breached the standards listed above. Mr. Biftu has admitted to failing in his professional responsibility and accountability. He did not practice in a manner that is consistent with the ethical values and obligations, and he did not maintain the standard of ensuring proper documentation and reporting. Mr. Biftu made multiple medication documentation errors.

Mr. Biftu failed to practice with honesty and integrity, and he did not practice in a manner that was consistent with the values and beliefs as expressed in the CLPNA Standards of Practice as well as the CLPNA Code of Ethics.

(9) Joint Submission on Penalty

The Complaints Officer and Mr. Biftu jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #3. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

1. The Hearing Tribunal’s written decision (the “Decision”) shall serve as a reprimand.

2. Mr. Biftu shall pay 10% of the costs of the investigation and hearing to a maximum of \$2,500.00, to be paid over a period of **24 months** of service of the Decision.
 - a) A letter advising of the final costs will be forwarded when final costs have been confirmed.
3. Mr. Biftu shall read and reflect on how the following CLPNA documents will impact his nursing practice. These documents are available on CLPNA's website and will be provided. Mr. Biftu shall provide a signed written declaration to the Complaints Officer within 30 days of service of the Decision, attesting that he has reviewed the documents:
 - a) Code of Ethics for Licensed Practical Nurses in Canada;
 - b) Standards of Practice for Licensed Practical Nurses in Canada;
 - c) CLPNA Policy: Professional Responsibility & Accountability;
 - d) CLPNA Policy: Documentation;
 - e) CLPNA Policy: Medication Management

If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Officer.

4. Mr. Biftu shall complete the remedial education course, at his own cost, **NURS 1061 Medication Management**, available through MacEwan University and provide a certificate confirming its successful completion to the Complaints Officer within **6 months** of service of the Decision.

If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Officer.

5. Mr. Biftu shall complete the remedial education course, at his own cost, **LPN Code of Ethics Learning Module**, available online at www.LearningNurse.com and provide a certificate confirming its successful completion to the Complaints Officer within **6 months** of service of the Decision.

If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Officer.

6. The sanctions set out above at paragraphs 2 - 5 will appear as conditions on Mr. Biftu's practice permit and the Public Registry subject to the following:
 - a) The requirement to pay costs, will appear as "Conduct Cost/Fines" on Mr. Biftu's practice permit and the Public Registry until all costs have been paid as set out above at paragraphs 2.
 - b) The requirement to complete the remedial education and readings outlined at paragraphs 3 - 5 will appear as "CLPNA Monitoring Orders (Conduct)", on Mr.

Biftu's practice permit and the Public Registry until the below sanctions have been satisfactorily completed:

- i. Educational Readings;
- ii. NURS 1061 Medication Management; and
- iii. LPN Code of Ethics Learning Module.

7. The conditions on Mr. Biftu's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 2 – 5.
8. Mr. Biftu shall provide the CLPNA with his contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information, and keep his contact information current with the CLPNA on an ongoing basis.
9. Should Mr. Biftu be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Officer.
10. Should Mr. Biftu fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Officer may do any or all of the following:
 - (a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;
 - (b) Treat Mr. Biftu's non-compliance as information for a complaint under s. 56 of the *Health Professions Act*; or
 - (c) In the case of non-payment of the costs described in paragraph 3 above, suspend Mr. Biftu's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

Legal Counsel for the Complaints Director submitted the primary purpose of orders from the Hearing Tribunal is to protect the public. The Hearing Tribunal is aware that s. 82 of the Act sets out the available orders the Hearing Tribunal is able to make if unprofessional conduct is found.

The Hearing Tribunal is aware, while the parties have agreed on a joint submission as to penalty, the Hearing Tribunal is not bound by that submission. Nonetheless, as the decision-maker, the Hearing Tribunal should give deference to a joint submission unless the proposed sanction is unfit, unreasonable or contrary to public interest. Joint submissions make for a better process and engage the member in considering the outcome. A rejection of a carefully crafted agreement would undermine the goal of fostering cooperation through joint submissions and may significantly impair the ability of the Complaints Director to enter into such agreements. If the Hearing Tribunal had concerns with the proposed sanctions, the proper process is to notify the

parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns through further submissions to the Hearing Tribunal.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Mr. Biftu and the Complaints Officer.

(10) Decision on Penalty and Conclusions of the Hearing Tribunal

The Hearing Tribunal recognizes its orders with respect to penalty must be fair, reasonable and proportionate, taking into account the facts of this case.

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Mr. Biftu has engaged in. In making its decision on penalty, the Hearing Tribunal considered a number of factors identified in *Jaswal v Newfoundland Medical Board* [1986] NJ No 50 (NLSC-TD), specifically the following:

- The nature and gravity of the proven allegations
- The age and experience of the investigated member
- The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
- The age and mental condition of the victim, if any
- The number of times the offending conduct was proven to have occurred
- The role of the investigated member in acknowledging what occurred
- Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made
- The impact of the incident(s) on the victim, and/or
- The presence or absence of any mitigating circumstances
- The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
- The need to maintain the public's confidence in the integrity of the profession
- The range of sentence in other similar cases

Applying those factors to this case,

1. **The nature and gravity of the proven allegations:** LPNs are expected to follow proper documentation requirements and medication administration requirements. When considered on a scale of seriousness of impact, this is not the most serious type of conduct as compared to gross or willful neglect, but nonetheless, it is still serious conduct as this is a basic core competency of what should be expected of an LPN. This is a failure to meet the minimum obligations of the profession and documentation of what has been done in nursing care. It is also the primary communication tool that is used to share information in a healthcare setting.

2. **The age and experience of the investigated member:** Mr. Biftu has been a regulated member of CLPNA since 2016. As an experienced member of the profession, he should have known of the importance of accurate documentation.
3. **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:** To the knowledge of the Hearing Tribunal, there were no other complaints or convictions against Mr. Biftu.
4. **The age and mental conditions of the victim:** The Hearing Tribunal did not receive specific details in respect of this factor.
5. **The number of times the offending conduct was proven to have occurred:** The conduct only occurred once.

The role of the investigated member in acknowledging what occurred: Mr. Biftu acknowledged what occurred and cooperated with the investigation. As a result of that cooperation this hearing took place by an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as well as a Joint Submission on Penalty. This demonstrates that Mr. Biftu did acknowledge what occurred, which is a mitigating factor for the Hearing Tribunal.

6. **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:** The Hearing Tribunal was not made aware of any such information.
7. **The impact of the incident(s) on the victim, and/or:** No information was provided to the Hearing Tribunal in this regard.
8. **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice:** The CLPNA handles allegations of unprofessional conduct by its members seriously. The penalties imposed needs to ensure that both Mr. Biftu is aware that the proven conduct will not be tolerated as well as ensuring the other members of the profession that conduct such as that in the proven allegation will be taken seriously.
9. **The need to maintain the public's confidence in the integrity of the profession:** The public needs to trust the regulated members of the CLPNA. The penalties in this case are intended, in part, to demonstrate to the public that the College takes such matters seriously and to ensure the public is protected.
10. **The range of sentences in other similar cases:** The Hearing Tribunal is of the belief that the range of sentence being sought is similar to the penalties ordered in similar cases.

It is important to the profession of LPNs to maintain the CLPNA Code of Ethics and the CLPNA Standards of Practice, and in doing so to promote specific and general deterrence and, thereby, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter, and again considered the seriousness of the Investigated Member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that actions and unprofessional conduct such as this is not tolerated and it is intended that these orders will, in part, act as a deterrent to others.

After considering the proposed orders for penalty, the Hearing Tribunal finds the Joint Submission on Penalty is appropriate, reasonable and serves the public interest and therefore accepts the parties' proposed penalties.

(11) Orders of the Hearing Tribunal

The Hearing Tribunal is authorized under s. 82(1) of the Act to make orders in response to findings of unprofessional conduct. The Hearing Tribunal makes the following orders pursuant to s. 82 of the Act:

1. The Hearing Tribunal's written decision (the "Decision") shall serve as a reprimand.
2. Mr. Biftu shall pay 10% of the costs of the investigation and hearing to a maximum of \$2,500.00, to be paid over a period of **24 months** of service of the Decision.
 - a) A letter advising of the final costs will be forwarded when final costs have been confirmed.
3. Mr. Biftu shall read and reflect on how the following CLPNA documents will impact his nursing practice. These documents are available on CLPNA's website and will be provided. Mr. Biftu shall provide a signed written declaration to the Complaints Officer within 30 days of service of the Decision, attesting that he has reviewed the documents:
 - a) Code of Ethics for Licensed Practical Nurses in Canada;
 - b) Standards of Practice for Licensed Practical Nurses in Canada;
 - c) CLPNA Policy: Professional Responsibility & Accountability;
 - d) CLPNA Policy: Documentation;
 - e) CLPNA Policy: Medication Management

If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Officer.

4. Mr. Biftu shall complete the remedial education course, at his own cost, **NURS 1061 Medication Management**, available through MacEwan University and provide a certificate confirming its successful completion to the Complaints Officer within **6 months** of service of the Decision.

If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Officer.

5. Mr. Biftu shall complete the remedial education course, at his own cost, **LPN Code of Ethics Learning Module**, available online at www.LearningNurse.com and provide a certificate confirming its successful completion to the Complaints Officer within **6 months** of service of the Decision.

If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Officer.

6. The sanctions set out above at paragraphs 2 - 5 will appear as conditions on Mr. Biftu's practice permit and the Public Registry subject to the following:

- a) The requirement to pay costs, will appear as "Conduct Cost/Fines" on Mr. Biftu's practice permit and the Public Registry until all costs have been paid as set out above at paragraphs 2.
- b) The requirement to complete the remedial education and readings outlined at paragraphs 3 - 5 will appear as "CLPNA Monitoring Orders (Conduct)", on Mr. Biftu's practice permit and the Public Registry until the below sanctions have been satisfactorily completed:
 - iv. Educational Readings;
 - v. NURS 1061 Medication Management; and
 - vi. LPN Code of Ethics Learning Module.

7. The conditions on Mr. Biftu's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 2 – 5.

8. Mr. Biftu shall provide the CLPNA with his contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information, and keep his contact information current with the CLPNA on an ongoing basis.

9. Should Mr. Biftu be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Officer.

10. Should Mr. Biftu fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Officer may do any or all of the following:

- (a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

- (b) Treat Mr. Biftu's non-compliance as information for a complaint under s. 56 of the *Health Professions Act*; or
- (c) In the case of non-payment of the costs described in paragraph 3 above, suspend Mr. Biftu's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

The Hearing Tribunal believes these orders adequately balances the factors referred to in Section 10 above and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected.

Under Part 4, s. 87(1)(a),(b) and 87(2) of the Act, the Investigated Member has the right to appeal:

"87(1) An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that

- (a) identifies the appealed decision, and
- (b) states the reasons for the appeal.

(2) A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

DATED THIS 2nd DAY OF DECEMBER 2024 IN CALGARY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA



Sarah Kawaleski, LPN
Chair, Hearing Tribunal